THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Cocaine

Powder cocaine and the patterns around it. A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. COCAINE CAUSES HEART ATTACKS AND STROKES IN PEOPLE OF ALL AGES.** Chest pain, jaw or left-arm pain, shortness of breath, or a sudden severe headache during or after use is an emergency: call 911. Do not wait, and do not assume it is anxiety.
>
> Also call 911 for confusion, slurred speech, facial drooping, arm weakness, seizure, a body temperature above 104°F, or extreme agitation or psychosis. There is no reversal agent for cocaine overdose: care is supportive. Never combine cocaine with alcohol.
>
> Crisis: call or text 988 · SAMHSA: 1-800-662-4357 · Never Use Alone: 1-800-484-3731

1. Before you start

This is a route through the Recovery Kernel for people recovering from powder cocaine, and for the people supporting them. Crack cocaine is the same molecule with a different route and its own guide (Supplemental Ch. 13), which this guide points to where it matters. Five rules set the order of everything that follows.

- **The heart comes first.** Cocaine can cause a heart attack in a healthy 25-year-old through coronary spasm, a norepinephrine surge, and increased clotting. Withdrawal itself is not medically dangerous, but the medical assessment belongs in the first week, not months in.
- **Never mix it with alcohol.** Together they form cocaethylene, longer-lasting and more cardiotoxic than either alone, and responsible for a significant share of cocaine deaths.
- **Get a blood count.** Most of the current supply is cut with levamisole, a veterinary deworming drug that can destroy white blood cells. Fever, mouth sores, a severe sore throat, or unusual infections need an emergency department the same day.
- **Design recovery for the brain you have.** The Kernel calls cocaine the Warrior's drug. A calm, quiet life will feel insufficient for this constitution. The route builds genuine intensity, not just rest.
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 12 (How to Recover from Cocaine); Chapter 13 covers crack cocaine. Section numbers (§) refer to sections inside those chapters.

A note on protocol numbers. Supplemental Chapter 12 cites Compendium protocols by number, and some numbers do not match the Compendium as printed. It calls Protocol 03 "exercise" (printed: Sonic Architecture; exercise is Protocol 19), Protocol 07 "nutrition" (printed: Neuroplasticity; nutrition is Protocol 18), Protocol 05 "environmental redesign" (printed: Digital Detox), Protocol 20 the identity protocol (printed: Mapping the Terrain), and Protocol 01 "Shelter" (printed: Emergency Triage). This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.

For cocaine, watch for redosing every time the short peak fades — each redose inside a session compounds cardiac risk far faster than it restores the high.

Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: cardiac and stroke signs, levamisole signs, no alcohol, no using alone.	Supp. Ch. 12 §0 Main Book, Quick-Start Step 1 Compendium P01
1	Days 0–7	Medical assessment: heart, blood count, nose, infections. Ride out the crash.	Supp. Ch. 12 §§3, 4.5, 7 Supp. Ch. 13 if crack
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs.	Supp. Ch. 5 Step 1 Supp. Ch. 12 §2 Compendium P06
4	Weeks 2–6	Resolve your combined profile. Ask about ADHD.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 12 §§2, 4.4
5	Day 1 to Month 6	Build the biological foundation: dopamine, serotonin, methylation, sleep.	Supp. Ch. 12 §4 Supp. Ch. 5 Phase One Compendium P18, P07, P17, P09
6	Weeks 2–12, then ongoing	Leave cues immediately. Learn the behavioral-first craving interrupt.	Supp. Ch. 12 §5 Compendium P20, P21, P08, P33, P05

Step	When	What you do	Turn to
7	Months 1–24	Build the Warrior's intensity architecture and social confidence without the drug.	Supp. Ch. 12 §6 Supp. Ch. 36, 3 Compendium P19, P03, P29
8	From week 1	Ask about medication options and ADHD treatment. Keep cardiac follow-up.	Supp. Ch. 12 §8, §4.4 Supp. Ch. 38 Compendium P44, P13
9	Months 2–12+	Identity (including work identity), inventory, family.	Supp. Ch. 42, 43, 51 Compendium C-28, P23, P24, P22
10	Year 1 to Year 10	Steward: review, transplant, coach others.	Supp. Ch. 44, 6, 38 Compendium P02, P13 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Know the cardiac signs above and act on them. Cocaine narrows and can spasm the coronary arteries shut, so clean arteries are no protection, and the heart is asked to work at maximum while its blood supply drops. Know the levamisole signs: fever, mouth sores, severe sore throat, or unusual susceptibility to infection, typically 1 to 3 weeks after exposure and easy to mistake for ordinary illness. Go to an emergency department, say you use cocaine, and ask for a complete blood count. The Kernel estimates levamisole in roughly 70 to 80 percent of the US supply and notes that fentanyl test strips do not detect it. It usually reverses within 2 to 3 weeks of stopping.

The Kernel's opioid chapter notes that fentanyl now contaminates supplies beyond heroin, including cocaine, so keep naloxone available even if you do not use opioids, and never use alone. Cocaine overdose is managed by supportive care while it clears: cooling for hyperthermia (ice packs at the neck, armpits, and groin, plus 911), a quiet environment for agitation, and the recovery position for seizure.

Turn to: Supp. Ch. 12 §0 (the cardiac emergency; cocaethylene; overdose recognition; the levamisole crisis). Supp. Ch. 18 §0 (naloxone and fentanyl in the supply). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Medical assessment and the crash (Days 0–7)

Cocaine withdrawal has no seizure risk and is not medically dangerous. It is psychologically brutal, in proportion to how much the drug was filling a real need. The crash in the first 24 hours brings profound fatigue, deep low mood, extreme hunger, and strong craving. Do not fight it: sleep, eat, hydrate. Days 1 to 3 are a honeymoon, a partial rebound that feels like recovery and is not. Use it to build your supplement stack and routine, because the cravings return, often stronger.

Schedule these in the first week: a cardiac evaluation (ECG, blood pressure, and an echocardiogram if you have symptoms or a heavy history, since cocaine cardiomyopathy is documented); a complete blood count now and repeated at 1 and 3 months for levamisole; an ENT evaluation if you snorted, since septum and palate damage and loss of smell can occur; HIV, hepatitis B and C testing and an endocarditis check if you injected; STI testing if use occurred in sexual settings; and an ADHD evaluation if it applies (Step 4). Cocaine's cardiac damage is progressive, so the assessment is safety, not optional self-care.

Turn to: Supp. Ch. 12 §3 (the detox protocol and withdrawal timeline), §4.5 (physical recovery: nasal, cardiovascular, infectious, levamisole monitoring), §7 (the Medical Assessment row). If you smoked crack: Supp. Ch. 13, which covers pulmonary risks and the most severe crash in the stimulant category.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are physically stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the Warrior profile is cocaine's primary genomic target), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still using → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning), which includes Case 04, the cocaine case, and sets your expectations. Supp. Ch. 3 (The Addict Virgin Problem), which recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

For cocaine, the single highest-priority finding is **COMT** Val158Met, because Val/Val (Warrior) changes the whole architecture of recovery. Next come **DAT1/SLC6A3** (the transporter cocaine blocks; the 10-repeat allele is also linked to ADHD), **DRD2/ANKK1**, **SLC6A4**, **MTHFR**, **DRD4** (the 7-repeat allele, novelty seeking), **BDNF** Val66Met, and **CYP3A4**. Add CYP2B6 if bupropion is considered, since poor metabolizers reach much higher levels at standard doses. Until results arrive, use the phenotype questions: did cocaine make you feel like the most alive, capable version of yourself; did the first line never quite suffice; is the sober baseline flat rather than depressed; do you suspect ADHD?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 12 §2 (DNA testing panel for cocaine recovery; phenotyping without test results). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your combined profile (Weeks 2–6)

Cocaine has the most precisely defined constitutional profile in the series: Warrior COMT, often with DRD2 A1 and a methylation deficit. That combination is a double deficit. The dopamine was cleared too fast before cocaine and is cleared even faster during recovery. Write your profile down and carry key results on a card.

If your result is...	What changes	Source
COMT Val/Val (Warrior)	Fast clearance, flat baseline. Cocaine gave the aliveness the baseline could not. Recovery needs genuine intensity, not calm.	Supp. Ch. 12 §2; Main Book Ch. 3
DAT1 10-repeat / DRD4 7-repeat	Higher transporter expression and novelty seeking. Linked to ADHD, and cocaine is a documented self-medication route. Ask about ADHD evaluation and build novelty and challenge into recovery.	Supp. Ch. 12 §§2, 4.4
DRD2 A1	Fewer D2 receptors. With Val/Val, a double deficit. Build several dopamine sources at once, never one.	Supp. Ch. 12 §2; Ch. 5 System 5
SLC6A4	Sets the size of cocaine's serotonergic effect: the social warmth and confidence. Long/long carriers may feel it most. Serotonin rebuilding is co-primary.	Supp. Ch. 12 §2, §4.3
MTHFR variants	5-MTHF addresses a genuine synthesis deficit. The flat early baseline may be partly a methylation state, not only withdrawal. Avoid synthetic folic acid with any T variant.	Supp. Ch. 12 §2, §4.1; Main Book Ch. 2
BDNF Met carrier	Reduced repair signal on top of cocaine's suppression of BDNF. Exercise becomes non-optional.	Supp. Ch. 12 §2
CYP3A4 / CYP2B6	CYP3A4 inhibitors (some antifungals, some antibiotics, grapefruit) can prolong cocaine's effect. CYP2B6 poor metabolizers accumulate bupropion at standard doses.	Supp. Ch. 12 §§2, 8

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 12 §2 and §4.4 (the ADHD question). Main Book Ch. 5 and Appendix A.

Step 5 — Build the biological foundation (Day 1 to Month 6)

Cocaine blocked the reuptake of dopamine, serotonin, and norepinephrine at once, so the Kernel prescribes a triple reconstruction on top of a methylation foundation. Dopamine is the central project: precursor support, receptor rehabilitation through a membrane-building stack, and NAC, which the Kernel calls one of the highest-evidence supplements for cocaine specifically. Serotonin is co-primary, unlike in the methamphetamine guide, because the social ease cocaine provided was substantially serotonergic. Norepinephrine recovers through exercise and rest. Sleep repair follows the compendium's stimulant-withdrawal sonic protocol: slow, warm, low-volume audio, because stimulating audio destabilizes a hypersensitive nervous system. The dose tables are in the chapter below. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape). The peptide layer in Supp. Ch. 12 §4.7 is labeled by the Kernel as needing physician discussion; one entry, Dihexa, is described as very potent with limited human data, so it is not a self-start step.

Turn to: Supp. Ch. 12 §4.1 (methylation), §4.2 (dopamine reconstruction), §4.3 (serotonin reconstruction), §4.6 (sleep), §4.7 (peptides, physician only). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 18 (Eating for Restoration), Protocol 17 (The Nightly Restoration), Protocol 07 (Neuroplasticity), Protocol 09 (The Gut-Brain Axis), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — Cues, cravings, and the social scene (Weeks 2–12, then ongoing)

Cocaine craving is one of the most cue-reactive in addiction medicine: a song, a smell, a place, or a person can fire the dopamine anticipation circuit before you have had a thought. So the interrupt is behavioral before it is cognitive. If a cue is present, leave the environment immediately and do not negotiate. Then a high-intensity physical interrupt (a sprint, jumping jacks, cold water on the face), because a Warrior craving fires at high voltage and needs a high-intensity counter-signal; six cycles of 4-7-8 breathing; your supplements; one contact; and the highest-intensity natural reward you can reach. The Kernel names five trigger types: environmental cues, social and performance contexts, dopamine-deficit flatness ("I just want to feel something"), social-confidence craving, and phantom smell, which resolves with time and is evidence recovery is working.

Cocaine was the social drug, so the social environment has to be replaced, not just reduced. Pre-plan high-risk events: arrive late and leave early, bring a sober support person, and have an exit ready. The Kernel says the Warrior profile has its best projected outcome when the environment is redesigned first.

Turn to: Supp. Ch. 12 §5 (the craving trigger map; the 5-minute interrupt). Compendium Protocol 20 (Mapping the Terrain), Protocol 21 (Reading the Collapse), Protocol 08 (Social Environment), Protocol 33 (The Boundary Architect), Protocol 05 (Digital Detox), Protocol 04 (Meeting Alternatives).

Step 7 — Build the Warrior's intensity architecture (Months 1–24)

The Kernel's frame: the Warrior was never looking for escape. It was looking for aliveness and a fight worth having. The Warrior does not become a Sage in recovery, and the need for intensity does not go away. What goes away is the need to flood the system with something that breaks the heart. The sources, in the Kernel's order: high-intensity exercise, where intensity matters more than duration and a short all-out interval session may beat a long jog; direct competition; high-stakes professional performance built on real preparation; creative mastery with an audience; cold exposure combined with exercise, a norepinephrine route to alertness without cardiovascular toxicity; social depth; and service, called the most reliable long-term dopamine source for the Warrior.

Rebuild social confidence deliberately. Cocaine's serotonin effect and years of performing on it are separate. The serotonin comes back with abstinence and support; the skill needs practice. Start in lower-stakes settings, prepare thoroughly instead of relying on chemistry, and use a recovery community as a training ground.

Turn to: Supp. Ch. 12 §6 (the Warrior's natural dopamine architecture; the social confidence architecture). Supp. Ch. 36 (Roots and Reversal). Supp. Ch. 3 (timeline recalibration). Compendium Protocol 19 (The Body in Motion), Protocol 03 (Sonic Architecture), Protocol 29 (The Peacetime Paradox).

Step 8 — Medication and ADHD (from week 1)

Unlike opioids, benzodiazepines, and alcohol, there is no FDA-approved medication for cocaine use disorder, which the Kernel calls a genuine treatment gap. What exists: bupropion (modest craving evidence, stronger for withdrawal depression, and it also treats ADHD); modafinil or armodafinil (for early cognitive impairment and fatigue); naltrexone (modest evidence, strongest in OPRM1 A118G carriers, and more relevant if alcohol is also a problem); GLP-1 agonists (emerging); and disulfiram (mixed evidence, and it requires absolute alcohol abstinence). If ADHD is confirmed, the Kernel calls non-stimulant treatment (atomoxetine, bupropion, guanfacine, viloxazine) one of the most clinically impactful interventions available, because cocaine was the focus drug. Discuss all of it with an addiction medicine physician.

Turn to: Supp. Ch. 12 §8 (medications with evidence; genomic considerations) and §4.4 (the ADHD question). Supp. Ch. 38 (questions to ask about medication duration). Compendium Protocol 44 (GLP-1 Receptor Agonists in Recovery), Protocol 13 (The Pharma Trap).

Step 9 — Identity and rebuilding a life (Months 2–12+, revisited later)

Many people with cocaine use disorder built a professional or social identity on cocaine's performance boost, so "I can't do my job without it" is a real concern. The identity work asks what genuine competence looks like when it rests on real capacity. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Family, money, and work follow.

Turn to: Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Compendium Protocol 23 (Rebuilding the Ledger), Protocol 24 (Returning to Work), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 10 — The long game (Year 1 to Year 10)

The Kernel maps the first year of cocaine recovery in detail and does not project beyond it. Navigation after that shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	Heart, CBC, ENT check; no alcohol mixing	Cardiac follow-up; medication review [1]	Annual cardiac and blood check	Heart risk stays; no alcohol mixing [7]
Biology and genome	COMT, DRD2, DAT1; 5-MTHF base	Retest labs; step stack to upkeep [2]	Prescriber card: COMT, CYP2B6	Re-check with new meds and age
Cues and environment	Cue exits; social scene replaced	Cues still fire; interrupt ready	Triggers shift: work, parties [5]	Same plan, rehearsed
Intensity architecture	Intensity daily: sprint, compete	Competition and craft carry the load [3]	Several intense outlets	Intensity outlets, still weekly
Sleep, mood, social ease	Crash, sleep; serotonin rebuild	Social ease, practiced sober	Mood plan, clinician-led	Stress plan, sleep habits
Identity and inventory	Identity from month 2; work identity	Inventory; real competence built	Sober community established	Annual re-inventory
Meaning and Manning	Purpose: first seeds only	Transplant; return to work [4]	Manning: coach, peer recovery [6]	Mentor or run a group

The seven shifts

1. **Year 3, cardiac follow-up and medication review.** The Kernel says cocaine's cardiac damage is progressive and that cocaine cardiomyopathy is documented with heavy chronic use (Supp. Ch. 12 §4.5), so scheduled follow-up continues after the early assessments. Review whichever medications you use (bupropion, modafinil, naltrexone, ADHD treatment) using the standard in Compendium Protocol 13: is each still needed, and what marks readiness to stop?
2. **Year 3, the stack moves from building to upkeep.** The Kernel places dopamine and serotonin systems as largely normalized by months 3 to 12 (Supp. Ch. 12 §3). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, competition and craft carry the load.** The Warrior architecture (Supp. Ch. 12 §6) is no longer a bridge across a flat baseline; it is your ordinary week. Because Warrior intensity needs do not go away, keep several outlets, since single-source reward is fragile for a DRD2 A1 profile.

4. **Year 3, meaning moves up.** As the repair tracks drop to maintenance, redirect the devotion and daily structure cocaine required into a practice (Supp. Ch. 44) and return to work (Compendium Protocol 24).
5. **Year 5, triggers shift from cues to context.** As cue-driven craving fades, what remains is what the Kernel names as performance and social contexts: work events, parties, and situations where cocaine once preceded the performance (Supp. Ch. 12 §5). Keep the pre-planning habit and Protocol 21 ready.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). The Kernel calls service the most reliable long-term dopamine source for the Warrior and says such a person can be among the most effective recovery coaches for others with that profile (Supp. Ch. 12 §6).
7. **Year 10, the heart risk does not reset the way the craving does.** Cocaine can cause a fatal heart attack in a healthy person, alcohol makes it worse through cocaethylene, and there is no reversal agent (Supp. Ch. 12 §0). If a lapse ever happens, treat chest pain as an emergency and never combine it with alcohol. Keep annual cardiac checks.

What is sourced and what is extrapolated. *Shifts 3, 6, and 7 rest directly on Kernel text. Shifts 1, 2, and 5 apply Kernel rules at a timing chosen for this guide. Shift 4 is an extrapolation. The Kernel's detailed cocaine timeline ends at about 12 months, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years for heavy long-term use. Years 3, 5, and 10 are therefore projections.*

5. What outcome to expect

The short version

If you do the route above, with triage and the medical assessment first, the triple biological reconstruction, cue redesign, the Warrior's intensity architecture and social confidence rebuilt, medication and ADHD questions handled, and then identity and purpose work, this is the outcome the Kernel projects:

- **You get through the medical window and the crash.** Your heart and blood count are checked, levamisole is caught if present, and the honeymoon is not mistaken for recovery.
- **Days 3 to 28 are the most dangerous relapse period,** with persistent anhedonia and cue-triggered craving. Then months 1 to 3 bring gradual return of emotional range, and months 3 to 12 bring near-normal hedonic capacity, with cravings mainly contextual.
- **By month 12 the Kernel's Case 04 is "performing from a rebuilt platform, not a borrowed one."** The same intensity that drove the use is driving something real.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards, above all the heart.

The Kernel does not promise zero risk or that a return to use cannot happen. It states that cocaine's cardiac danger is independent of age and prior health, that there is no approved medication, and that cue-triggered craving can return months into recovery.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
The crash	Hours 0–24	Profound fatigue and hypersomnia, deep low mood, extreme hunger, strong craving. Not medically dangerous. Sleep, eat, hydrate.	Supp. Ch. 12 §3	Clinical timeline
The honeymoon	Days 1–3	A partial rebound that feels like recovery. Cravings return, often stronger. Use the window to build the stack and routine.	Supp. Ch. 12 §3	Kernel projection
Withdrawal proper	Days 3–28	Persistent anhedonia, cue-triggered craving, depression, cognitive impairment, poor sleep. The most dangerous relapse period.	Supp. Ch. 12 §3	Kernel projection
Levamisole reverses	2–3 weeks after stopping	Agranulocytosis, if present, typically reverses. Repeat blood counts at 1 and 3 months.	Supp. Ch. 12 §§0, 4.5	Kernel projection
Early recovery	Months 1–3	D2 receptors upregulating; genuine moments of pleasure returning; PAWS likely, dominated by cue-triggered craving.	Supp. Ch. 12 §3	Kernel projection
Consolidation	Months 3–12	Dopamine and serotonin largely normalized. Near-normal hedonic capacity. Cravings mainly contextual. Motivation returning.	Supp. Ch. 12 §3	Kernel projection
Deep-root reversal	2–5+ years (heavy long-term use)	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Purpose and service. Standing safeguards, including cardiac follow-up.	Section 4 of this guide	Extrapolated

The Kernel's own 12-month numbers for one cocaine profile

Supplemental Chapter 2 gives projected outcomes at 12 months for an adherent protocol compared with standard treatment. Case 04 is a 34-year-old startup CEO who used cocaine on weekends "to keep up" and by now uses Tuesday through Sunday, sleeps four hours, and has lost his appetite. His profile is COMT Val/Val, likely DRD2 A1, and likely MTHFR heterozygous. The Kernel notes this Warrior profile has its best projected outcome when the environment is redesigned first.

Case	Measure	Kernel protocol	Standard treatment
Case 04	Sustained abstinence or cessation at 12 months	65%	20%
Case 04	Significant mood and motivation improvement at Month 3	78%	25%
Case 04	Exercise protocol adherence (the key mediator)	72%	30%

Case	Measure	Kernel protocol	Standard treatment
Case 04	Craving reduction of 60% or more with the full dopamine stack	68%	15%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol, drawn from cited studies and NIDA baselines. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. Case 04's protocol also includes bupropion with a prescriber, so the result is not supplements alone.*

What changes the outcome

- **Ignoring chest pain, jaw or arm pain, or a sudden severe headache.** These are emergencies at any age.
- **Mixing with alcohol.** Cocaethylene is a longer-lasting, more cardiotoxic third compound.
- **Skipping the first-week medical assessment,** or missing levamisole signs (fever, mouth sores, severe sore throat, infections).
- **Mistaking the honeymoon for recovery.** Days 1 to 3 are a partial rebound, and the hardest stretch is days 3 to 28.
- **Staying in the cue environment.** The Kernel says to leave immediately and not negotiate, and to replace the social scene rather than reduce it.
- **A calm-life prescription for a Warrior.** Rest-only or gentle-only plans fail by understimulation. The route needs genuine intensity.
- **Leaving ADHD untreated** when cocaine was the focus drug.
- **A single source of reward,** for a DRD2 A1 double-deficit profile.
- **Unprepared high-risk social events,** and injection or smoking routes without the infectious and pulmonary follow-up.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also a cardiac-risk event with no reversal agent: do not use alone, do not add alcohol, and call 911 for chest pain.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: cocaine's cardiac danger, the cocaethylene interaction, and levamisole-related agranulocytosis are documented clinical concerns. The Kernel itself states that there is no FDA-approved treatment, rates bupropion as modest evidence, disulfiram as mixed, GLP-1 agonists as emerging, and calls NAC one of the highest-evidence supplements for cocaine. The supplement stack, the intensity-architecture claims, the peptide layer (including Dihexa, which the Kernel notes has limited human data), the percentage projections, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- An honest account of your use: route (snorted, smoked, injected), how often, how long, and whether alcohol was involved.
- A request for a cardiac evaluation, a complete blood count now and at 1 and 3 months, and an ENT check if you snorted. If you injected, HIV, hepatitis B and C testing and an endocarditis check.
- Your COMT, DAT1, DRD2, MTHFR, and CYP results (CYP2B6 if bupropion is considered), and any ADHD symptoms so an evaluation can be arranged.
- A direct question about bupropion, modafinil or armodafinil, naltrexone, GLP-1 agonists, and non-stimulant ADHD treatment, including how long each would be used and what marks readiness to review it.
- Every supplement you take, with doses, so interactions can be checked.